CHILD HEALTH BC
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HIP SURVEILLANCE PROGRAM
for Children with Cerebral Palsy

For office use only:

ENROLLMENT FORM

Hip surveillance is a plan for regular check-ups using clinical exams and hip x-rays to watch for signs that your child's hip may be moving out of joint. You/your child have been invited to participate in the **Child Health BC Hip Surveillance Program** because you/your child has been identified as being at risk for having the hip move out of joint.

I, _____, hereby agree to participate/have my child _____ participate in the Child Health BC Hip Surveillance Program, which means (**please initial in boxes below**):

☐ I have been provided with the booklet "**What is Hip Surveillance and Why is it Important for My Child?**"

☐ I have been given the opportunity to ask questions and have had satisfactory response to my questions.

☐ I understand that this will involve regular clinical exams of my/my child's hips by my/my child's physiotherapist or other health care provider.

☐ I understand that this will involve the review of my/my child's hip x-rays and relevant health information by the program's physician and/or coordinator at BC Children's Hospital.

☐ I understand a report will be provided to me and to my/my child's physiotherapist (when completing the clinical exams), primary care provider (Family Doctor or Pediatrician), and orthopaedic surgeon as listed here by me. Please provide contact information for these healthcare providers:

Physiotherapist	Agency and City	Phone
Physician Name	Address and City	Phone
Ortho Surgeon Name	Address and City	Phone

Consent for Mailing: May we send you information on new resources and/or research that may be of benefit to you and your child related to cerebral palsy and/or hip health? ❑ Yes ❑ No

If yes, please indicate your preferred method of delivery:

❑ mail ❑ email, please provide your email address: _____

Signature of Child/Youth	Name (Print)
Signature of Legal Guardian	Name of Legal Guardian (Print)
Date	(____)_____ Telephone Number

The information on this form is collected for the purpose of enrolling in the Child Health BC Hip Surveillance Program. It is collected under the authority of section 26(c) of the BC Freedom of Information and Protection of Privacy Act. For additional information, please see www.childhealthbc.ca/hips or contact the program coordinator by email: hips@cw.bc.ca or phone: 604-875-2345 extension 4099.

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Child/Youth's Name:_____ DOB: _____ (dd/mth/yr)

TO BE COMPLETED BY THE INTERPRETER (if applicable):

I confirm that I have explained the nature of the above consent to the above-named patient (and/or legal guardian) in the presence of _____ and to the best
Witness Name (Print)
of my knowledge the context of this consent form is understood.

_____ _____/_____/_____
Signature of Interpreter Day Month Year

_____
Interpreter Name (Print)

Please return completed Enrollment Package to:

Child Health BC Hip Surveillance Program

Fax: 604-875-2387

Mail: BC Children's Hospital
Orthopaedic Department, Room ID62
4480 Oak Street
Vancouver, BC
V6H 3V4

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ENROLLMENT FORM
CLIENT INFORMATION

Date:_____(dd/mth/yr)

Last Name: _____First & Middle Names: _____

Date of Birth: _____ (dd/mth/yr) PHN: _____

Gender: ❑ Male ❑ Female ❑ Other _____

Mailing Address*:* _____

City: _____ Postal Code: _____

Born in BC: ❑ Yes ❑ No If No, arrived in BC in: _____ (mth/yr)

Contact Information

Primary Caregiver's Last Name: _____ First Name: _____

Relationship to the Child: _____ Legal Guardian ❑ Yes ❑ No

Mailing Address*:* (❑ same as above) _____

City: _____ Postal Code: _____

Phone Number: _____ ❑ Home ❑ Cell ❑ Work

Phone Number: _____ ❑ Home ❑ Cell ❑ Work

Email: _____

Interpreter Required: ❑ Yes ❑ No If yes, language_____

Alternate Caregiver's Last Name: _____ First Name: _____

Relationship to the Child: _____ Legal Guardian ❑ Yes ❑ No

Mailing Address (❑ same as above) _____

City: _____ Postal Code: _____

Phone Number: _____ ❑ Home ❑ Cell ❑ Work

Phone Number: _____ ❑ Home ❑ Cell ❑ Work

Email: _____

Interpreter Required: ❑ Yes ❑ No If yes, language_____

Would you like correspondence go this mailing address? ❑ Yes ❑ No *(if no, primary address will be used)*

 Name: _____ DOB: _____/_____/_____ (dd/mth/yr)

MCFD/DAA Involvement

MCFD/DAA involvement: ❑ Yes ❑ No

If yes, Social Worker Last Name: _____ First Name: _____

SW is Legal Guardian: ❑ Yes ❑ No If yes, does foster parent have authority to make non invasive healthcare decisions (e.g. consent to an x-ray)? ❑ Yes ❑ No (*please ask foster parent to confirm this)*

Mailing Address _____

City: _____ Postal Code: _____

Phone Number: _____ (Work) Phone Number: _____ (Cell)

Fax Number: _____ Email: _____

Would you like correspondence go to this mailing address? ❑ Yes ❑ No *(if no, primary address will be used)*

Relevant History

Has the child/youth had a hip/pelvis x-ray in the past? ❑ Yes ❑ No ❑ Unknown

If yes, Date of most recent x-ray: _____ (dd/mth/yr)

Hospital/Clinic where x-ray completed: _____

Has the child/youth seen an Orthopaedic surgeon in the past? ❑ Yes ❑ No ❑ Unknown

If yes, surgeon's name: _____

Is the child still followed by this surgeon? ❑ Yes ❑ No Next appointment (approximate):_____

Has the child had surgical intervention for hip displacement? ❑ Yes ❑ No

If yes, list (including approx. date):_____

_____

Enrolling Clinician Information

Name: _____ ❑ PT ❑ OT ❑ MD ❑ Other: _____

Agency: _____

Mailing Address*:* _____

City _____ Postal Code: _____

Work Phone Number: _____ Alternative Phone: _____

Fax Number: _____ Email: _____

Did you identify this child for hip surveillance? ❑ Yes ❑ No

If No, who identified? ❑PT ❑OT ❑MD ❑Parent ❑Other _____ Name: _____

Fax completed forms to: 604-875-2387

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CLINICAL EXAM

Child's Last Name: _____First & Middle Names: _____

Date of Birth: _____ (dd/mth/yr) PHN: _____

See the CLINICAL EXAM INSTRUCTIONS for definitions and exam descriptions

Diagnosis: ❑ Cerebral Palsy (CP) ❑ Possible CP, not yet confirmed ❑ Other* (specify) _____

**If known, specify name of child's condition/syndrome. Note: children diagnosed with known conditions (e.g genetic, metabolic, chromosomal, etc) may also be described as having CP if their clinical presentation is consistent with the definition of CP*

Step 1: Classify:

a) GMFCS level **REQUIRED** *(select **one**)*: ❑ I ❑ II ❑ III ❑ IV ❑ V

b) MACS level, if known *(select **one**)*: ❑ I ❑ II ❑ III ❑ IV ❑ V

c) CFCS level, if known *(select **one**)*: ❑ I ❑ II ❑ III ❑ IV ❑ V

d) Motor Distribution:

❑ Unilateral (hemiplegia) ↓

If unilateral:

i) Affected side: ❑ Right ❑ Left

ii) Type IV hemiplegic gait? ❑ No ❑ Yes

OR

❑ Bilateral ↓

If bilateral, select all affected limbs:

❑ Right Upper ❑ Left Upper

❑ Right Lower ❑ Left Lower

e) Motor type *(Select **all** that apply)*: ❑ Spasticity ❑ Dystonia ❑ Athetosis ❑ Chorea ❑ Ataxia ❑ Hypotonia

Step 2: Assess:

a) Hip abduction ROM (hips & knees at 0° flexion): Right: _____°, Left: _____ ° ❑ Not tested

**If not tested or unable to test reliably, please provide a brief reason in the Comments section below.*

b) Pain present during clinical exam: ❑ Yes ❑ No ❑ Unknown ❑ Not tested

Step 3: Ask the child and/or child's parent/primary caregiver

1. Do [does] you [your child] have hip pain? You may notice this when you move [your child moves] your [their] hip or after prolonged activity, when changing your [your child's] position, when you move you [your child's] leg or when looking after your [your child's] personal care.

❑ Yes
❑ No
❑ Unknown

Comments: _____

_____

_____

Date of Clinical Exam: _____/_____/_____ (dd/mth/yr) Completed by: ❑PT ❑OT ❑MD ❑Other _____

Clinician's Name: _____

Agency: _____Phone: _____

Assisting Clinician's Name (if applicable):_____

Fax completed forms to: 604-875-2387